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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

PATIENT CARE ASSOCIATES LLC, a/s/o B.C., A.R., and K.W., Plaintiff, v. NESTLÉ; ABC CORP. (1-10) (said names being fictitious and unknown entities) Defendant.	Civil Action No. 13-CV 1480 (WJM) (MF) **DECLARATION OF DANA LOCH IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS THE COMPLAINT**

DANA LOCH, of full age, declares as follows:

1. I am the Human Resources Employee Benefits Manager for Nestlé Waters North America Inc. ("NWNA"). I make this declaration based upon my personal knowledge for the purpose of presenting to the Court copies of certain sections of the NWNA Medical Choice Plus Plan ("NWNA Choice Plus Plan") and the NWNA Medical Choice Plus Plan with UHC Health Fund Health Reimbursement Account

("NWNA Health Fund Plan") in effect during 2011 when the plaintiff alleges in its complaint it rendered services to the persons it describes as B.C., A.R., and K.W.

2. Annexed hereto as Exhibit "A" is a copy of "Section 9 - Claims Procedures" of the Summary Plan Description of the NWNA Choice Plus Plan effective as of January 1, 2010 which sets forth that Plan's claims procedures, including sections on how and when to appeal the denial of a claim for benefits. This Plan provides at least two levels of appeal.

3. Annexed hereto as Exhibit "B" is a copy of a summary of those changes to the NWNA Choice Plus Plan made to "Section 9 - Claims Procedures" effective January 1, 2011.

4. During 2011, A.R. and K.W. were participants in the NWNA Choice Plus Plan.

5. Annexed hereto as Exhibit "C" is a copy of "Section 9 - Claims Procedures" of the Summary Plan Description of the NWNA Health Fund Plan effective January 1, 2010 which sets forth that Plan's claims procedures, including sections on how and when to appeal the denial of a claim for benefits. This Plan also provides at least two levels of appeal.

6. Annexed hereto as Exhibit "D" is a copy of a summary of those changes to the NWNA Health Fund Plan made to "Section 9 - Claims Procedures" effective January 1, 2011.

7. During 2011, B.C. was a participant in the NWNA Health Fund Plan.

I declare under penalty of perjury that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Dated: March 28, 2013

DANA LOCH

EXHIBIT A

Summary Plan Description

Nestlé Waters North America
Medical Choice Plus Plan

Effective: January 1, 2010
Group Number: 333000

UnitedHealthcare
Healing health care. Together.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network Provider, UnitedHealthcare will pay the Physician or facility directly. If a Network Provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the Provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network Provider at the time of service, or when you receive a bill from the Provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network Provider, you (or the Provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Employee;
- the number as shown on your ID card;
- the name, address and tax identification number of the Provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the Provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and

- a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with us at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network Provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

UnitedHealthcare will pay Benefits to you unless:

- the Provider notifies UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that Provider; or
- you make a written request for the non-Network Provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your Provider has assigned Benefits to that third party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits or post-service claim as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the Provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your enrolled Dependent may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your Provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination. UnitedHealthcare must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final.

Voluntary External Review

If, after exhausting the two levels of appeal, you are not satisfied with the final determination, you may choose to participate in the voluntary external review program. This program only applies if the claim denial is based on:

- clinical reasons; or
- the exclusions for Experimental or Investigational Services or Unproven Services.

The voluntary external review program is not available if the claim denial is based on explicit benefit exclusions or defined benefit limits. Contact UnitedHealthcare at the toll-free number on your ID card for more information.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**48 hours** after receiving notice
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**72 hours**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**48 hours**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
	receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal*

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Nestlé Waters North America or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Nestlé Waters North America or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Nestlé Waters North America or the Claims Administrator.

You cannot bring any legal action against Nestlé Waters North America or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Nestlé Waters North America or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against Nestlé Waters North America or the Claims Administrator.

EXHIBIT B

SUMMARY OF MATERIAL MODIFICATIONS
To the Summary Plan Description for
Nestlé Waters North America
Effective January 1, 2011

A Summary Plan Description (SPD) was published effective January 1, 2010. The following are modifications and clarifications that are effective January 1, 2011 unless otherwise stated. These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD.

In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPD, the provisions of this SMM shall govern.

Section 2: Introduction	
Under Heading:	**The Following Should be Noted:**
Eligibility	**Replace the second paragraph with the following.** Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be: ■ your Spouse, as defined in Section 14, Glossary; ■ your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or ■ an unmarried child age 26 or over who is or becomes disabled and dependent upon you.
Changing Your Coverage	**Remove the following bullet from the list.** ■ you or your eligible Dependent incurs a claim that would exceed a lifetime limit on all benefits under the elected health care option through Nestlè Waters North America;
Dependent Child Special Open Enrollment Period	**Add the following language at the end of the section immediately after the Changing Your Coverage section.** **Dependent Child Special Open Enrollment Period** On or before the first day of the plan year beginning on or after September 23, 2010, the Plan will provide a 30 day dependent child special open enrollment period for Dependent children who have not yet reached the limiting age. During this dependent child special open enrollment period, Participants who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Section 9: Claims Procedures	
Under Heading:	**The Following Should be Noted:**
How to Appeal a Denied Claim	**Replace the first paragraph with the following.** If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include: ■ the patient's name and ID number as shown on the ID card; ■ the provider's name; ■ the date of medical service; ■ the reason you disagree with the denial; and ■ any documentation or other written information to support your request.
External Review Program	**Add the following language immediately following the section titled 'Review of an Appeal'. This replaces the existing shaded box titled 'Voluntary External Review Program'.** **External Review Program** If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on: ■ clinical reasons; ■ the exclusions for Experimental or Investigational Services or Unproven Services; or ■ as otherwise required by applicable law. This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if UnitedHealthcare fails to respond to your appeal within the time lines stated below. You may request an independent review of the adverse benefit determination. Neither you nor UnitedHealthcare will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. All requests for an independent review must be made within

Section 9: Claims Procedures	
Under Heading:	**The Following Should be Noted:**
	four (4) months of the date you receive the adverse benefit determination. You, your treating Physician or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card. The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by UnitedHealthcare and has no material affiliation or interest with UnitedHealthcare or. UnitedHealthcare will choose the IRO based on a rotating list of approved IROs. In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO. Within applicable timeframes of UnitedHealthcare's receipt of a request for independent review, the request will be forwarded to the IRO, together with: ■ all relevant medical records; ■ all other documents relied upon by UnitedHealthcare in making a decision on the case; and ■ all other information or evidence that you or your Physician has already submitted to UnitedHealthcare. If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and UnitedHealthcare will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law. The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and UnitedHealthcare with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law. If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and

<table>
<tr><th colspan="2">Section 9: Claims Procedures</th></tr>
<tr><th>Under Heading:</th><th>The Following Should be Noted:</th></tr>
<tr><td></td><td>conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.</td></tr>
<tr><td>Timing of Appeals Determinations</td><td>Replace the table that describes the timeframes for appealing an Urgent Care Request.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

<table>
<tr><th colspan="2">Urgent Care Request for Benefits*</th></tr>
<tr><th>Type of Request for Benefits or Appeal</th><th>Timing</th></tr>
<tr><td>If your request for Benefits is incomplete, UnitedHealthcare must notify you within:</td><td>24 hours</td></tr>
<tr><td>You must then provide completed request for Benefits to UnitedHealthcare within:</td><td>48 hours after receiving notice of additional information required</td></tr>
<tr><td>UnitedHealthcare must notify you of the benefit determination within:</td><td>24 hours</td></tr>
<tr><td>If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:</td><td>180 days after receiving the adverse benefit determination</td></tr>
<tr><td>UnitedHealthcare must notify you of the appeal decision within:</td><td>72 hours after receiving the appeal</td></tr>
</table>
*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.</td></tr>
</table>

Section 9: Claims Procedures	
Under Heading:	**The Following Should be Noted:**
Concurrent Care Claims	**Replace the language in its entirety with the following.** ***Concurrent Care Claims*** If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Section 12: When Coverage Ends	
Under Heading:	**The Following Should be Noted:**
Other Events Ending Your Coverage	**Remove the following language from the section.** The Plan will provide written notice to you that your coverage has ended if any of the following occur: ■ you permit an unauthorized person to use your ID card or you use another person's ID card; ■ you knowingly give UnitedHealthcare false material information including, but not limited to, false information relating to another person's eligibility or status as a Dependent; ■ you commit an act of physical or verbal abuse that imposes a threat to Nestlè Waters North America's staff, UnitedHealthcare's staff, a provider or another Covered Person; or ■ you violate any terms of the Plan. **Add the following language under a new heading entitled "Other Events Ending Your Coverage":** ***Other Events Ending Your Coverage*** The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if: ■ you commit an act, practice, or omission that constituted

EXHIBIT C

Summary Plan Description

Nestlé Waters North America Medical Choice Plus Plan with UHC Health Fund Health Reimbursement Account

Effective: January 1, 2010
Group Number: 333000

Nestlé Waters

UnitedHealthcare
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SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- how network and non-network claims work; and
- what to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network Provider, UnitedHealthcare will pay the Physician or facility directly. If a Network Provider bills you for any Covered Health Service other than your Coinsurance, please contact the Provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Member Responsibility phase of the Annual Deductible and paying any Coinsurance owed to a Network Provider at the time of service, or when you receive a bill from the Provider.

When you receive Covered Health Services from a Network Provider funds in your FSA or HRA will be deducted first for those Covered Health Services based on your balance at the time of service and may be used to help you meet your Annual Deductible. You are responsible for any difference between the amount of Eligible Expenses the Plan pays and the total Eligible Expenses. Any funds left in your HRA may be used to assist you in paying this difference, up to the network Out-of-Pocket Maximum. If no funds are available in your FSA or HRA, you will be responsible for payment of the Eligible Expenses until the Member Responsibility phase of the Annual Deductible is met. Once your Annual Deductible is met, the Plan will pay a percentage of your Covered Health Services until you meet the Out-of-Pocket Maximum — after which the Plan will pay 100% of any additional Covered Expenses you incur during that calendar year.

If your Provider does not file a claim on your behalf, follow the procedures under non-network Benefits below.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network Provider, you (or the Provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If you have funds in your HRA and you receive Covered Health Services from a non-Network Provider, you are responsible for filing a request for reimbursement. You can only submit a claim for reimbursement from your HRA funds for expenses incurred while you are a Covered Person under the Plan.

You must submit a claim for reimbursement from your HRA for any other types of expenses other than Covered Health Services and any health expenses not submitted to UnitedHealthcare.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting myuhc.com, calling the toll-free number on your ID card or contacting Nestlé HR Service Center. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Employee;
- your member ID number as shown on your ID card;
- the name, address and tax identification number of the Provider of the service(s);
- the date of service;
- an itemized bill from the Provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
  - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with us at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network Provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

UnitedHealthcare will pay Benefits to you unless:

- the Provider notifies UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that Provider; or
- you make a written request for the non-Network Provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your Provider has assigned Benefits to that third party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper health statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Nestlé Waters North America . This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Requesting Reimbursement from Your HRA

If you have funds available in your HRA and you received services from a non-Network provider you may submit a claim for reimbursement for the additional medical expenses from your HRA. If you do choose to submit a request for reimbursement, the request must be received no later than 90 days following date of service. If you don't provide this information to the Claims Administrator within this timeframe, your claim will not be eligible for reimbursement, even if there are funds available in your HRA. This time limit does not apply if you are legally incapacitated.

You cannot be reimbursed for any expense paid under your medical plan, and any expenses for which you are reimbursed from your HRA cannot be included as a deduction or credit on your federal income tax return.

Important
You are responsible for paying the provider for the service at the time of service or when you receive a bill from the provider. If you have funds available in your HRA, you can submit a claim for reimbursement of your costs. If there are no funds available in your HRA, you are responsible for the entire cost of the services.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the Provider's name;
- the date of medical service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

You or your eligible Dependent may send your written request for an appeal to:

Claims Administrator
UnitedHealthcare - Appeals
PO Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care claims that have been denied, you or your Provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, you should determine whether it is an:

- urgent care;
- pre-service;
- post-service; or
- concurrent care claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

UnitedHealthcare has two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal. UnitedHealthcare must notify you of the benefit determination within 15 days after receiving the completed appeal for a pre-service claim and 30 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final.

Voluntary External Review

If, after exhausting the two levels of appeal, you are not satisfied with the final determination, you may choose to participate in the voluntary external review program. This program only applies if the claim denial is based on:

- clinical reasons; or
- the exclusions for Experimental and Investigational Services or Unproven Services.

The voluntary external review program is not available if the claim denial is based on explicit benefit exclusions or defined benefit limits. Contact UnitedHealthcare at the toll-free number on your ID card for more information.

Timing of Claim Denials and Appeals

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are four types of claims:

- Urgent Care - a claim for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service - a claim for Benefits which the Plan must approve before non-Urgent Care is provided;
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided; and
- Concurrent Care – a claim for continuation of Benefits for an on-going course of treatment that was previously approved for a specific period of time or number of treatments.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed claim information to UnitedHealthcare within:	**48 hours** after receiving notice
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**72 hours**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care claim appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care claim.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal*

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

**This timeframe assumes that UnitedHealthcare gives notice of the need for an extension during the initial 15-day period.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision

Post-Service Claims	
Type of Claim or Appeal	**Timing**
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

**This timeframe assumes that UnitedHealthcare gives notice of the need for an extension during the initial 30-day period.

Important Note
When your claim is processed at UnitedHealthcare two important dates are used:

- The date on which you received a Covered Health Service from your Provider is used to process claims for the health coverage. This allows your Deductible, Coinsurance, and Out-of-Pocket Maximum to account for the moment in time when you receive a Covered Health Service.
- The date on which you received a Covered Health Service from your Provider is used when deducting Benefit Dollars from your HRA. This allows the Benefit Dollars in your HRA to act like a savings account, available for your use when your claim is paid.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care claim and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Nestlé Waters North America or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Nestlé Waters North America or the Claims Administrator, you must do so within three years from the expiration

of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Nestlé Waters North America or the Claims Administrator.

You cannot bring any legal action against Nestlé Waters North America or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Nestlé Waters North America or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against Nestlé Waters North America or the Claims Administrator.

EXHIBIT D

SUMMARY OF MATERIAL MODIFICATIONS
To the Summary Plan Description for
Nestlé Waters North America
Effective January 1, 2011

A Summary Plan Description (SPD) was published effective January 1, 2010. The following are modifications and clarifications that are effective January 1, 2011 unless otherwise stated. These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD.

In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPD, the provisions of this SMM shall govern.

Section 2: Introduction	
Under Heading:	**The Following Should be Noted:**
Eligibility	**Replace the second paragraph with the following.** Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be: ■ the Participant's Spouse and or a same-sex or opposite-sex Domestic Partner, as defined in Section 14, Glossary; or ■ any Dependent Child under 26 years of age, including a natural child, stepchild, a legally adopted child, and a child whom you or your Spouse are the legal guardian.
Changing Your Coverage	**Remove the following bullet from the list.** ■ you or your eligible Dependent incurs a claim that would exceed a lifetime limit on all benefits under the elected health care option through Nestlè Waters North America;
Dependent Child Special Open Enrollment Period	**Add the following language at the end of the section immediately after the Changing Your Coverage section.** **Dependent Child Special Open Enrollment Period** On or before the first day of the plan year beginning on or after September 23, 2010, the Plan will provide a 30 day dependent child special open enrollment period for Dependent children who have not yet reached the limiting age. During this dependent child special open enrollment period, Participants who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Section 8: Exclusions	
Under Heading:	**The Following Should be Noted:**
	7. tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act; 8. learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; 9. mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; 10. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction; and 11. intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders; and 12. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Section 9: Claims Procedures	
Under Heading:	**The Following Should be Noted:**
How to Appeal a Denied Claim	**Replace the first paragraph with the following.** If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include: ■ the patient's name and ID number as shown on the ID card; ■ the provider's name; ■ the date of medical service; ■ the reason you disagree with the denial; and ■ any documentation or other written information to support your request.
External Review Program	**Add the following language immediately following the section titled 'Review of an Appeal'. This replaces the existing shaded box titled 'Voluntary External Review Program'.**

Section 9: Claims Procedures	
Under Heading:	**The Following Should be Noted:**
	External Review Program If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on: ■ clinical reasons; ■ the exclusions for Experimental or Investigational Services or Unproven Services; or ■ as otherwise required by applicable law. This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if UnitedHealthcare fails to respond to your appeal within the time lines stated below. You may request an independent review of the adverse benefit determination. Neither you nor UnitedHealthcare will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You, your treating Physician or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card. The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by UnitedHealthcare and has no material affiliation or interest with UnitedHealthcare or. UnitedHealthcare will choose the IRO based on a rotating list of approved IROs. In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO. Within applicable timeframes of UnitedHealthcare's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

Section 9: Claims Procedures	
Under Heading:	**The Following Should be Noted:**
	■ all relevant medical records; ■ all other documents relied upon by UnitedHealthcare in making a decision on the case; and ■ all other information or evidence that you or your Physician has already submitted to UnitedHealthcare. If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and UnitedHealthcare will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law. The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and UnitedHealthcare with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law. If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure. You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

<table>
<tr><th colspan="2">Section 9: Claims Procedures</th></tr>
<tr><th>Under Heading:</th><th>The Following Should be Noted:</th></tr>
<tr><td>Timing of Appeals Determinations</td><td>
Replace the table that describes the timeframes for appealing an Urgent Care Request.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.
<table>
<tr><th colspan="2">Urgent Care Request for Benefits*</th></tr>
<tr><th>Type of Request for Benefits or Appeal</th><th>Timing</th></tr>
<tr><td>If your request for Benefits is incomplete, UnitedHealthcare must notify you within:</td><td>24 hours</td></tr>
<tr><td>You must then provide completed request for Benefits to UnitedHealthcare within:</td><td>48 hours after receiving notice of additional information required</td></tr>
<tr><td>UnitedHealthcare must notify you of the benefit determination within:</td><td>24 hours</td></tr>
<tr><td>If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:</td><td>180 days after receiving the adverse benefit determination</td></tr>
<tr><td>UnitedHealthcare must notify you of the appeal decision within:</td><td>72 hours after receiving the appeal</td></tr>
</table>
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</td></tr>
</table>

Section 9: Claims Procedures	
Under Heading:	**The Following Should be Noted:**
Concurrent Care Claims	**Replace the language in its entirety with the following.** ***Concurrent Care Claims*** If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Section 12: When Coverage Ends	
Under Heading:	**The Following Should be Noted:**
Other Events Ending Your Coverage	**Remove the following language from the section.** The Plan will provide written notice to you that your coverage has ended if any of the following occur: ■ you permit an unauthorized person to use your ID card or you use another person's ID card; ■ you knowingly give UnitedHealthcare false material information including, but not limited to, false information relating to another person's eligibility or status as a Dependent; ■ you commit an act of physical or verbal abuse that imposes a threat to Nestlè Waters North America's staff, UnitedHealthcare's staff, a provider or another Covered Person; or ■ you violate any terms of the Plan. **Add the following language under a new heading entitled "Other Events Ending Your Coverage":** ***Other Events Ending Your Coverage*** The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if: ■ you commit an act, practice, or omission that constituted